

Appointment Date: _____

Appointment Time: _____

Patient's Full Legal Name		Patient's Marital Status S M D W	
Patient's Home Address, City, State, Zip Code		Patient's Social Security #	
Patient's Home Phone	Patient's Work Phone	Patient's Mobile/Cell Phone	Patient's Pager Number
If the patient is a CHILD - Father's Name and Cell Phone Number		If the patient is a CHILD - Mother's Name and Cell Phone Number	
Whom does Patient live with?		Patient's Date of Birth	Patient's Age
Patient's Employer Name and Address (include City, State, and Zip)			

Referring Physician or Hospital

Responsible Party's Name, Address, City, State, Zip			
Responsible Party's Date of Birth	Responsible Party's Age	Responsible Party's Social Security #	How Are You Related To The Patient
Responsible Party's Home Phone	Responsible Party's Work Phone	Responsible Party's Mobile/Cell Phone	Responsible Party's Pager Number
Responsible Party's Employer Name, and Address (include City, State, and Zip)			

**INSURANCE INFORMATION: PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST
IN ADDITION TO COMPLETING THE INFORMATION BELOW**

Primary Insurance Company Name	Policy Number or Social Security #	Group Number
Insurance Company Claim Address (include City, State, and Zip)		
Policy Holder of Insurance	Policy Holder's Date of Birth	How is the patient related to the policy holder ___Self ___Spouse ___Child ___Other

Secondary Insurance Company Name	Policy Number or Social Security #	Group Number
Insurance Company Claim Address (include City, State, and Zip)		
Policy Holder of Insurance	Policy Holder's Date of Birth	How is the patient related to the policy holder ___Self ___Spouse ___Child ___Other

Pharmacy Name, Address and Phone Number

Emergency Contact Person, Address (include City, State, and Zip), Phone Number and Cell Phone Number (NOT LIVING IN PATIENTS' HOME)

Panhandle Ear, Nose & Throat Associates, L.L.P. complies with HIPAA regulations, therefore we require that you complete the following section. Please understand that we can only share information with the person(s) and/or organization(s) that you list. Any person(s) and/or organization(s) that are not listed can only receive information after the patient or the patient's responsible party has signed a release of information form. The list below will be considered valid for a period of year (1) year unless a written request is received by the patient or the responsible party revoking consent.

I _____ grant permission for Panhandle Ear, Nose & Throat Associates, L.L.P. and its authorized personnel to release information to the following person(s) and/or organization(s) about my appointments, bills, medical treatment, medical plan and any other information associated with my being a patient.

Name	Date of Birth	Phone Number	Will this person be bringing the patient to their appointments?
Address	Relationship	Work Number	
Name	Date of Birth	Phone Number	Will this person be bringing the patient to their appointments?
Address	Relationship	Work Number	
Name	Date of Birth	Phone Number	Will this person be bringing the patient to their appointments?
Address	Relationship	Work Number	
Name	Date of Birth	Phone Number	Will this person be bringing the patient to their appointments?
Address	Relationship	Work Number	

May we leave a message about your appointment on your answering machine?	Yes	No
May we leave a message about your medical condition on your answering machine?	Yes	No
May we leave a message for a return call at your work?	Yes	No

According to the Texas Family Code 35.01 - states, a minor must be accompanied by a parent for treatment, unless one of the following applies to the patient. 1) the minor is on active duty with the armed forces of the USA. 2) the minor resides apart from his/her parents and manages their own financial affairs. 3) the minor has a disease which is reportable to Texas Department of Health. 4) the minor who is married and pregnant. 5) the minor is seeking treatment for an addiction. 6) the minor is seeking treatment for counseling such as suicide prevention, chemical addition or dependency or sexual, physical or emotional abuse. If you are a minor and one of the above do not apply, you must be accompanied by a parent.

I request that insurance benefits be made on my behalf to Panhandle Ear, Nose & Throat Associates, L.L.P. for any services furnished to the patient. I authorize and understand that Panhandle Ear, Nose & Throat Associates, L.L.P. holder of medical information about the patient to release to the insurance carrier(s) any information needed to determine the benefits payable on any services to the patient. I understand that a photocopy of this assignment is to be considered as valid as the original until revoked by the patient or responsible party in writing for a period of one (1) year. I UNDERSTAND THAT I AM FINANCIAL RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE CARRIER(S).

I have read and understand the above statements.

Responsible Party's Signature	Date
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